BRITISH COLUMBIA REVIEW BOARD

IN THE MATTER OF PART XX.1 (Mental Disorder) OF THE CRIMINAL CODE
R.S.C. 1985 c. C-46, as amended S.C. 2005 c. 22

IN THE MATTER OF THE FITNESS TO STAND TRIAL
AND
DISPOSITION HEARING OF

RALPH STANLEY CHICKITE

HELD AT: Forensic Psychiatric Hospital
Port Coquitlam, BC
27 March 2008

BEFORE: CHAIRPERSON: B. Walter
MEMBERS: Dr. R. Stevenson, psychiatrist
P. Barnsley

APPEARANCES: ACCUSED/PATIENT: Ralph Stanley Chickite
ACCUSED/PATIENT COUNSEL: K. Love
HOSPITAL/CLINIC: L. Lee Dr. M. Hediger
ATTORNEY GENERAL: L. Hillaby

[1] CHAIRPERSON: On March 27th, 2008 the British Columbia Review Board convened an early hearing following a short order to review the fitness to stand trial of and to make a disposition in the matter of Ralph Stanley Chickite, the accused, who is 52 years of age.

[2] The index offence with which Mr. Chickite stands charged, its circumstances, as well as his developmental and psychiatric impairments, have been commented on in the course of reasons for disposition given at the accused's first hearing which was as recently as December 11, 2007. We therefore do not propose to review all of that history in detail, although it remains under our consideration. We adopt the factual findings of the previous panel of the Review Board.

[3] There are some highlights relevant to our deliberations on this date: The accused was of course resident on his First Nations reserve, the Cape Mudge reserve on Quadra Island, at the time of the index offence and he continues to have access to his home in that community. The index offence consisted of the accused assaulting a visiting mental health or home support worker in his premises. We take into account that the accused had been the subject of a considerable number of previous reports of aggressive behaviour towards caregivers and, more recently in the current evidence, we learned towards community members as well.

[4] The accused has distant convictions for alcohol-related driving and narcotics possession which are now some 30 years in the past. Dr. Riley, who was asked to assess Mr. Chickite for the Court, found evidence of persistent assaultive behaviour primarily towards female care providers as well as threatening behaviour. It is that behaviour that Dr. Riley found had served to distance Mr. Chickite to some extent from members of his community and in particular supportive resources on his First Nations reserve.

[5] The accused's afflictions, which Dr. Hediger and Dr. Riley have agreed consist of dementia due to brain injury, had their onset in two serious head injuries, the first suffered in 1981 and the second in 1994, after which significant behavioural and functional problems began to be identified. Both of those traumas were occasioned in the course of motor-vehicle accidents. They have resulted in impairments including in Mr. Chickite's ability to communicate orally as well as in writing; impairments in his memory; instability of mood; sudden anger; irritability. They also include mobility or gait problems. There is some suspicion raised in Dr. Riley's report that the accused may also be a user of marijuana, although the evidence on that point remains vague.

[6] Dr. Riley also assumed, in the course of his explorations and assessment, that the accused was likely not compliantly consuming his antiseizure medications at the time of the index offence. However, he notes that the accused was unable to express himself verbally on that point. Dr. Riley was also of the view that the accused's periodic bouts of irritability or even his outbursts of violence might indeed be due to frustration resulting from his difficulties in communicating with others.

[7] In any event, in assessing the accused's fitness to stand trial on the assault, Dr. Riley found it impossible to communicate with the accused or to engage him in any meaningful discussion with respect to his understanding of court proceedings. He therefore opined that the accused could not be expected to understand legal proceedings or to communicate with counsel so as to render his participation in a trial meaningful.

[8] Unfortunately, this accused does not appear to be facile in or to be able to utilize any alternative form of communication or recognized form of sign language. He may not be able to learn any. Even at that early assessment stage, Dr. Riley expressed the tentative view that Mr. Chickite appeared to present with no realistic prospect of becoming fit to stand trial. On the basis of that expert assessment, the Court on September 17, 2007 determined that the accused was unfit to stand trial and proceeded to impose a disposition of detention, requiring the accused to be committed and held at the Forensic Psychiatric Hospital.

[9] Under such circumstances, the Review Board is, of course, required to convene a first or initial hearing within a 90-day period. The accused's first hearing was held on December 11th, 2007.

[10] Once the accused found himself lodged at FPH his progress was fraught with difficulty. Soon after his admission the accused struck a female staff. He was initially secluded due to agitated behaviour, outbursts and assaultive behaviour. He very soon found himself almost continuously secluded. In October he suffered a further fall during an apparent seizure and he once again sustained some form of head injury. In November he assaulted a co-patient causing injury. In her early report to the Review Board, prior to Mr. Chickite's first hearing, Ms. Lee documented a trend of increasing, escalating assaultive behaviour.

[11] Dr. Hediger provided his opinion with respect to fitness. That opinion was summarized by the panel of the Review Board in a quote from Exhibit 7. That quote is

found at paragraph 13 of the Board's reasons at Exhibit 8. We adopt it in its entirety. In summary, Dr. Hediger indicated that he had been unable to converse or communicate with the accused and felt that the accused remained unfit to stand trial as he would be unable to communicate meaningfully with his counsel.

[12] Dr. Hediger also expressed the opinion that he did not expect Mr. Chickite's situation to change significantly due to his historic brain injuries. The Board agreed. It formed the opinion that the accused remained unfit to stand trial and detained him at FPH, mainly to allow members of the accused's community and extended family on the Cape Mudge reserve to prove their capacity to care for Mr. Chickite in his own social milieu. It encouraged the Director to collaborate with reserve resources in developing a risk management and treatment plan for the accused.

[13] In reconvening the current hearing we have received a number of additional documentary submissions, in satisfaction of the Board's requirements articulated in December. Janice Ross, the forensic case manager at the Nanaimo Forensic Outpatient Clinic, has undertaken to meet with members of Mr. Chickite's community, with representatives of his district band council, his own band administrators, as well as with family members, with a view to assessing the nature and extent of community supports and services available to Mr. Chickite, should he be discharged from hospital and returned to that community.

[14] In essence, Ms. Ross identifies an array of in-home support needs that Mr. Chickite presents. She also indicates that the band stands ready to provide housekeeping or home support services; however, it will not do so while the accused is in his home due to his historic assaultive behaviour. The band is not prepared to provide more instrumental habilitation or advocacy in the form of a one-to-one healthcare worker.

[15] Ms. Ross' report contrasted, to some extent, with the evidence that developed in the course of today's hearing. She indicated that the accused's contact with his broader community, and even with members of his family and extended family, is somewhat minimal or limited. She also reminded us that as a result of past assaultive behaviour the accused currently has no identified personal or private physician or GP on Quadra Island or in Campbell River.

[16] The hospital-based case manager, Ms. Lee, also provided evidence in the form of a report which was received as Exhibit 12. She cites an ongoing and unpredictable

increase in terms of the accused's agitation and physical aggression. In support of that assertion she cites assaultive or aggressive events on a number of dates including December 13th, December 15th, December 17th, December 21st, December 23rd, December 25th, January 10th, February 15th, February 24th and February 26th. She also reminds us that the accused suffered another seizure on January 8th, 2008. However, she does allow that with the administration of the accused's antiseizure medications the accused's aggressive bouts appear to have ameliorated and decreased in frequency.

[17] Ms. Lee also documents or comments on a further forensic/family teleconference which occurred in March. The purpose of that teleconference was to assess the degree of support that the accused could expect from family members; to address what Dr. Hediger characterized as the gap between formal and informal supports that exists in meeting Mr. Chickite's various needs. Essentially, at the time of that teleconference, it was Ms. Lee's opinion that the family support plan remained unarticulated and vague or variable.

[18] Ms. Lee also references a report from band social development administrator, Anita Moon, which the Board received as Exhibit 10 in this proceeding. It emphasizes that the accused has been somewhat indiscriminate in his aggression, having assaulted multiple home support workers of different ethnicities and gender, and indicating that the band council no longer will provide home-care services to Mr. Chickite.

[19] Ms. Lee also reminded us that the accused, currently, has no doctor in Campbell River. The means to ensure that the accused's daily medication dosages are appropriately administered remains unascertained. She also highlighted that if the accused were discharged subject to conditions the forensic case manager, Janice Ross, would need to be accompanied on home visits for safety reasons. She indicated that Mr. Chickite's possibilities in terms of accessing community brain injured services are unlikely to come to fruition in the short term as he is low on a somewhat lengthy waitlist for such resources.

[20] We heard as well from the supervising psychiatrist, Dr. Hediger, who filed a report dated March 20th, 2008 at Exhibit 13. Again Dr. Hediger documents the accused's progress since his last hearing. He cites frequent episodes of unpredictable, impulsive violence and aggression, including what he termed somewhat serious assaults on staff members as well as on peers. He does indicate that in the last number of weeks these outbursts have ameliorated or lessened. He continues to endorse a diagnosis of trauma-induced dementia and epilepsy.

[21] Insofar as there were contesting positions with respect to the matter of disposition, the Board saw fit to bifurcate this hearing. We first dealt with evidence with respect to the matter of fitness to stand trial. Dr. Hediger began his evidence by indicating that there had been no significant change on the matter of fitness. Clearly, this man's significant brain injuries continue to affect his capacity to participate in court proceedings and he remains unable to communicate verbally.

[22] Dr. Hediger described his attempts to engage or interview Mr. Chickite in the context of a formal fitness assessment. He told us that the accused was unable to respond meaningfully or to reflect any understanding of the nature or object of judicial proceedings, nor was he able to respond to the nature of his charges or the possible consequences of a trial. When specifically questioned, Dr. Hediger identified no viable strategies which could be expected to restore Mr. Chickite to fitness to stand trial. He indicated that no further such tests or strategies were planned.

[23] Mr. Chickite communicates his needs mostly by pointing or gesturing. He is entirely averbal. When specifically asked Dr. Hediger offered the opinion that the accused's behaviour, although it might be in part due to frustrations arising from his communications deficits, clearly also stems from cognitive deficits which would be expected to affect his understanding and participation in a trial proceeding, irrespective of his communications impairments.

[24] Dr. Hediger commented that he did not believe the accused should be returned to court at this point. He again repeated in the context of his current report the quote that I have already referred to found at paragraph 13 of Exhibit 8 which indicates that in his professional opinion this accused falls short of satisfying the fitness to stand trial criteria which are articulated at Section 2 of the *Criminal Code* on any measure. He does not expect the accused's situation to change or that he will recover his fitness to stand trial.

[25] The accused's counsel offered no evidence which would allow us on a balance of probabilities to rebut the accused's presumptive lack of fitness to stand trial. We therefore have no alternative but to continue that finding.

[26] That left us to explore the issue of the accused's disposition which of course is restricted to two options, discharge subject to conditions or continuing his detention at this hospital. On that issue we of course have the documentary submissions already referred

to which evidence was augmented by Dr. Hediger. He once again reviewed for us the accused's clinical history since his admission to this hospital.

[27] As mentioned earlier, Dr. Hediger sought to take a balanced approach to the accused's ongoing detention versus his discharge to the care of family and community resources. Given the accused's identified needs, there exists what he termed a service gap between what can be formally provided by the accused's community and what can be informally carried out by members of his family and extended family.

[28] Dr. Hediger is of the view that the commitments of family and extended family members, that is, the nature and extent of the supports that they could provide to meet Mr. Chickite's needs, remains somewhat unclear or vague, notwithstanding that the family is prepared to assume the risks that Mr. Chickite's behaviour may from time to time occasion. Dr. Hediger would be more comfortable with a more articulated service and management plan to meet this accused's needs.

[29] On the issue of disposition, Mr. Love called a number of community and family members via teleconference. We heard from a Mr. Pidcock who is the accused's uncle and who is also accompanied by a number of other band and family members. Mr. Pidcock has known the accused all his life. He described for us a community in which Mr. Chickite is literally surrounded by family and extended family members. The accused occupies his own house. He has heretofore been able to function relatively independently in terms of meeting his daily living needs, albeit with the assistance of occasional housekeeping or homemaking services.

[30] Since being approached by FPS with a view to considering supportive resources and plans Mr. Pidcock indicates that members of the community and the family are prepared to provide the services they feel the accused needs, including supervision, the administration of his medications twice per day, as well as transport to and from medical and forensic appointments. They are also prepared to assist the accused in accessing a new personal physician.

[31] One barrier with respect to the efficacy of community services has been the upcoming fishing season which would see community members otherwise engaged and might leave Mr. Chickite unsupervised. Mr. Pidcock responds that fishing is such that he does not expect it to offer much in the way of distraction. He overall left us with the impression that not only does this community in the main wish to have the accused

returned to their midst but that the members of his family do not share the safety concerns articulated by other witnesses.

[32] Mr. Pidcock, importantly for our decision-making purposes, was also prepared to commit to full disclosure and the reporting of any difficulties or management challenges that may arise as a result of Mr. Chickite's behavior to the local forensic case manager. Under questioning, Mr. Pidcock was also prepared to opine that the accused may be less cognitively impaired than his behaviour would indicate. He told us in a humorous and affectionate way that the accused is a bit of a crafty con artist.

[33] We also heard from Mr. Brian Kelly, the Cape Mudge band administrator. His evidence is essentially that this accused is known to everyone in the community; that the accused's house remains available to him. Its maintenance is the responsibility of the band or council. The band is prepared to assist Mr. Chickite in terms of the weekday administration of his morning meds. They are prepared to provide housekeeping services as long as the accused is removed from the home during such periods of time.

[34] He supported Mr. Pidcock's evidence that the accused has demonstrated he can function relatively independently. He indicated that his community does want the accused home. He offered his own services to assist the family in developing a more detailed written plan of care and support than they have been able to provide to date. He made it clear that the band will not supply or provide personal or one-to-one support beyond housekeeping. Should that type of support be available to Mr. Chickite, we would certainly find it a valuable adjunct in terms of his service continuum.

[35] In closing, the treatment team and Mr. Hillaby, on behalf of the Attorney General of B.C., recommended the accused's ongoing detention and his replacement in the community on a visit leave basis pending the articulation of a more detailed, written management plan. Mr. Hillaby also acknowledged that given the distances involved and the accused's possible vulnerability to changes in his environment visit leaves of 60 days duration ought to be authorized by this tribunal.

[36] Mr. Love, on behalf of Mr. Chickite, argued for discharge subject to conditions, indicating that the current plan proffered, albeit verbally, by Mr. Chickite's community supports ought to be considered adequate for the time-being, especially as Mr. Chickite, with the administration of his new medication, is becoming more manageable and his violent outbursts are decreasing.

[37] The Review Board reserved its decision. We withdrew to consider carefully the lengthy testimony provided. Having already determined that the accused remains unfit to stand trial, we were left to grapple only with the matter of disposition. Although on the basis of Dr. Hediger's risk assessment that is found at Exhibit 13 we would have no hesitation in concluding that the accused can pose a significant threat to others on the basis of his historic and indeed more recent presentation in hospital, nonetheless we must also take into account the informed support of his community and family members.

[38] Under the circumstances, we were not persuaded that there is much to be gained by delaying the accused's discharge from this hospital. Clearly, Mr. Chickite wishes to return to his community. Clearly his community and family wants him back in their midst. Clearly Dr. Hediger, as the clinician, is open to and has properly considered the wisdom of that outcome, although on a somewhat delayed basis. There is no argument that this primarily forensic institution is not optimal in terms of meeting the accused's needs or maximizing his quality of life.

[39] Although we agree that the nature and extent of the support that can be mustered from members of the accused's family could benefit from greater articulation and from being reduced to writing as a means of solidifying commitments, we must also take into account the impressive level of support which has already been marshaled and which clearly exists on Mr. Chickite's reserve. All things considered, and mindful of the statutory admonition to impose the least onerous and least restrictive disposition, which does not unduly or inappropriately expose the community to risks, this panel was persuaded that Mr. Chickite could be discharged subject to conditions which will be articulated in our disposition. Under prevailing circumstances we also take into consideration the Ontario Court of Appeal's decision in **R. v. Sim** (Oct 20, 2005) which elevates the so-called **GLADUE** principles to the level of legally required considerations of Review Board dispositions proceedings: **par 12; par 16; par 19; par 22; 29.**

[40] It is, however, our understanding that members of his family and community will continue to collaborate cooperatively with the accused's outpatient treatment team and that when we next convene to once again review Mr. Chickite's situation we will be favoured or presented with an appropriate treatment plan which sees to his needs and which also adequately protects the community from Mr. Chickite's very predictable, periodic outbursts.

[41] CHAIRPERSON: Ms. Barnsley is of course still with me and I will ask her if she wishes to make any comments or additions or observations on the record at this point.

[42] MS. BARNSLEY: Not at this point. I think you've covered everything.

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Edits KW Apr 10/08